Countess Mountbatten of Burma Romsey Memorial Trust

# Edwina Mountbatten House

## Inspection report

Edwina Mountbatten House
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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

Edwina Mountbatten House is a care home without nursing. People in care homes receive accommodation and their care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection. The service provides accommodation for up to 16 people. There were 14 people using the service at the time of the inspection. The registered provider, Countess of Mountbatten of Burma Romsey Memorial Trust is also a registered charity run by a board of Trustees. The Trustees meet on a regular basis to discuss and decide on all issues concerning Edwina Mountbatten House.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At the last inspection, the service was rated overall as 'Good'. At this inspection we found the service was now rated overall as requires improvement.

Improvements were required to ensure staff were recruited safely and in line with regulatory requirements.

Although some people's care plans provided sufficient detail about how to mitigate known risks, others did not.

Improvements were needed to ensure that medicines were managed safely at all times.

New staff had not completed a training and development programme which helped to equip them with the right skills and knowledge to carry out their roles.

The provider had failed to meet a condition of their registration with the Care Quality Commission by admitting more than the maximum number of service users allowed.

More sophisticated systems were needed to support the registered manager and registered provider to measure the quality of service and delivery of care, treatment and support given to people against the fundamental standards, key lines of enquiry and best practice guidance.

Other areas were good.

There were sufficient numbers of staff deployed to meet people's needs at this time. The level of dependency of people using the service was increasing however, and so the registered manager would benefit from having a systematic approach in place to determine and review staffing levels. We have made a recommendation about this.

Pre-admission assessments were undertaken but we have made a recommendation about making these more comprehensive in order to support robust decisions about new admissions to the home.

The home was clean throughout, although we have made a recommendation that the registered manager ensure action is taken to fully incorporate statutory guidance in relation to infection control into the policies and procedures within the home.

Staff had received training in safeguarding adults, and displayed a commitment to protect people from abuse. Staff understood their responsibility to report incidents or accidents that could affect the safety and wellbeing of people using the service and these were monitored for trends or themes.

An internal redecoration and refurbishment programme was underway to help ensure the home design and layout met the needs of people using the service.

People's personal choices and freedoms were respected and people were encouraged and supported to make decisions about their care and support

People were positive about the food provided. People received and were supported to access healthcare services when needed.

People told us they were cared for by kind and caring staff who respected their choices, their privacy and dignity and encouraged them to retain their independence.

People received care that was responsive to their needs. Staff knew people well and had a good knowledge of their likes and dislikes.

People had access to a range of activities and leisure opportunities. People were involved in making decisions about their care and told us they were able to raise any issues or concerns and felt these would be dealt with promptly.

Basic end of life care plans were in place. We have made a recommendation about reviewing best practice guidance to support staff to help people and their relatives feel empowered and positive about talking about death and dying and recording their wishes in relation this.

People spoke positively about the registered manager who had a good knowledge about the people being cared for within the service. The registered manager had fostered a person centred culture within the home.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service had deteriorated to 'requires improvement'.

Improvements were required to ensure staff were recruited safely and in line with regulatory requirements.

Although some people's care plans provided sufficient detail about how to mitigate known risks, others did not. People's personal choices and freedoms were respected.

Improvements were needed to ensure that medicines were managed safely at all times.

There were sufficient numbers of experienced staff deployed to meet people's needs.

### Is the service effective?

**Requires Improvement**

The service had deteriorated to 'requires improvement'

New staff had not completed a training and development programme to ensure they were equipped with the right skills and knowledge to carry out their roles.

Improvements could be made to the robustness of the pre-admission assessment.

An internal redecoration and refurbishment programme was underway to help ensure the home design and layout met the needs of people using the service.

People and their relatives told us that staff sought their consent before providing care and that they were encouraged and supported to make decisions about their care and support

People were positive about the food provided. People received and were supported to access healthcare services when needed.

### Is the service caring?

**Good**

The service remained good.

## Is the service responsive?

Good

The service had improved to good.

## Is the service well-led?

Requires Improvement

The service had deteriorated to 'requires improvement'.

The provider had failed to meet a condition of their registration with the Care Quality Commission by admitting more than the maximum number of service users allowed.

More sophisticated systems were needed to support the registered manager and registered provider to measure the quality of service and delivery of care, treatment and support given to people.

People were supported to maintain links with the local community within which they lived.

People spoke positively about the registered manager who had a good knowledge about the people being cared for within the service.

# Edwina Mountbatten House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014

This was an unannounced inspection which took place over two days on 19 and 20 February 2018. On the first day of our visit, the inspection team consisted of one inspector. On the second day, the inspector was joined by an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of service.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification tells us about important issues and events which have happened at the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with nine people who used the service and the relatives of three people. We spoke with the registered manager, care manager, a member of the board of Trustees and two care staff. We reviewed the care records of three people in detail. We also looked at the records for four staff and other records relating to the management of the service such as audits, incidents and accident forms, policies and staff rotas.

Following the inspection we sought feedback from a number of health and social care professionals about the care provided at Edwina Mountbatten House. Two of these provided a response.

The last inspection of Edwina Mountbatten House was in October 2015 during which we identified that improvements were needed to ensure that records relating to people's care were more detailed.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe living at Edwina Mountbatten House. One person told us, "I do [feel safe] no reason not to here, everyone is lovely". Whilst people told us they felt safe, some improvements were needed to ensure the safety and welfare of people.

The registered manager had not ensured that all of the required checks took place before new staff started working at the home. The provider had obtained references from previous employers and checked with the Disclosure and Barring Service (DBS) to ensure the staff member had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post. However a full employment history had not been obtained for three of the four staff whose recruitment files we viewed. This information has now been obtained and measures put in place to ensure that this information is collected in full in future.

Staff knew the people they supported and were aware of people's individual risks and how this could impact on the person's health, wellbeing and safety. Risk assessments were in place in relation to areas such as falls and nationally recognised tools were being used to predict people's risk of developing skin damage or poor nutrition. We did note however, that some of the records relating to how risks were managed needed to be documented in a more robust manner and we have discussed this further under the well led domain. We did find that a strength of the service was the way in which staff supported people's freedom and choices and wherever possible minimised restrictions on people. For example, people continued to access the community and risk assessments and risk management plans were in place with regards to this. People told us they valued this.

Staff understood their responsibility to report incidents or accidents that could affect the safety and wellbeing of people using the service. The registered manager told us that such incidents and accidents were monitored monthly for trends or patterns so that remedial actions could be taken to prevent a reoccurrence. For example, following a fall, they advised that staff would look at the person's room to ensure all trip hazards had been removed and check whether there might have been a decline in the person's sight for example. This helped to ensure that potential risks to people were monitored and lessons learnt for the future.

During the inspection, we noted some concerns with regards to how risks to fire safety were being managed. We asked Hampshire Fire and Rescue Service to visit. They have issued a fire safety action letter which includes a number of actions that need to be addressed. We will check to see that these have been completed. We also noted that a legionella risk assessment completed in December 2016 had recommended a regime of weekly flushing of low use outlets. The registered manager told us that this was being completed on a monthly basis instead, but has now arranged for this to be done each week. People had personal emergency evacuation plans (PEEPs) which contained information about how staff should support them in the event of an evacuation or in an emergency. Monthly room inspections were undertaken which included checks that the hot water was not exceeding temperatures that could cause scalding. Electrical appliance and gas safety certificates were in place.

Suitable arrangements remained in place for ordering medicines and suitable checks continued to be made to ensure that these had been supplied correctly. Medicines were stored in a locked trolley, a medicines fridge or a locked cupboard. Controlled drugs were stored and administered safely. Controlled drugs (CD's) are medicines which are controlled under the Misuse of Drugs Act 1971 and which require special storage, recording and administration procedures. Staff administering medicines had received training and had their competency assessed on an annual basis. Each person had a medicines administration record (MAR) which contained the information needed to support the safe administration of medicines and medicines care plans gave information on how people liked to take their medicines. We observed people being given their medicines, this was managed in a safe and person centred manner.

We did note some areas for improvement with regards to medicine management. Many of the protocols in place for PRN or as required medicines simply replicated the information on the medicines packet. They were not personalised and did not prescribe the specific circumstances in which the person might require this medicine. Where PRN were being administered, staff were not consistently recording the reason why on the reverse of the MAR. This is important as it helps staff and healthcare professionals monitor the effectiveness of the PRN medicine. Where people's medicines were not provided in a monitored dosage system, staff were not maintaining a record of the amount left following the medicine being administered. This helps staff to monitor that people have sufficient amounts of medicines available at all times. A small number of medicines had been opened and were in use but had no date of opening recorded. This is important as medicines can become less effective once opened longer than recommended. We found at least ten occasions where people appear to have received their medicines, but the staff member had not signed the MAR to confirm this. The registered manager has told us that action is being taken to address each of these areas.

Overall people told us there were sufficient staff available to meet their needs. One person said, "Oh Yes, You've only got to ring the bell and someone come immediately". Staff told us there was usually sufficient staff to meet people's needs unless staff had rung in sick at short notice. For example, one staff member said, "Yes there is the right number of staff on duty…you don't have to leave people to answer buzzers… Everything gets done".

Currently morning shifts were led by the care manager or a senior carer supported by two care workers until 1pm. This then reduced to one care worker until 4.30pm when a second care worker was rostered to provide a twilight shift until 8.30pm to support people with their bedtime routines. In addition the registered manager was full time and available to support the staff team as necessary. At night there was one waking night care worker and one care worker sleeping in. We reviewed the rotas for a four week period; these confirmed the home was staffed to these target levels. Gaps in the rota were covered by the existing staff and bank staff. The provider also employed housekeeping staff, a chef and kitchen staff and a maintenance person. Agency staff were not currently being used. This helped to ensure that people were being supported by staff who were familiar with their needs.

Many of the people currently living at Edwina Mountbatten House needed minimal assistance with their personal care such as support with their medicines, taking a bath or with the provision of meals. Therefore the reduction to one staff member in the afternoons was currently working effectively. We spoke with the registered manager about the nature of people's needs and how staffing levels were determined. They did not currently use a specific tool for determining staffing numbers but acknowledged that people coming to live at the service now, were often more dependent, and had increasingly complex needs. They were also admitting an increasing number of people for respite or short term care which also had an impact on the staffing requirements. With this in mind, we recommend that the registered manager use a systematic tool to assist them in determining ongoing staffing numbers and ensure these reflect the needs of people using

the service and their changing dependency.

Each of the people we spoke with felt that the home was clean. Throughout our visit, we did not find any malodours and we observed that staff used appropriate personal protective equipment (PPE). The kitchen was clean and the service had recently been awarded the highest rating following a food hygiene inspection. The registered manager was not familiar with the statutory guidance from the Department of Health: 'Prevention and control of infection in care homes' and we therefore recommend that action is taken to ensure this is fully incorporated into the infection control policies and procedures within the home.

Staff had received training in safeguarding adults, and displayed a commitment to protect people from abuse. For example, one care worker told us, "If I had concerns, I would go the senior; if they didn't act I would go to the Trustees or CQC". The provider had a safeguarding policy in place which described the procedures and processes in place to safeguard people from harm and keeping people safe was discussed in staff supervisions. This helped to ensure that staff knew how to recognise and report allegations of abuse. Whistleblowing policies were in place and staff were familiar with these.

Requires Improvement

# Is the service effective?

## Our findings

People and their relatives told us the service provided effective care. One person said, "I reckon it's absolutely wonderful here…everyone's polite, the service is excellent…I'm happy here". One relative told us, "I am thrilled to bits; I couldn't praise the home enough". Another relative said, "I knew as soon as we set through the door that it felt right".

Records showed that the longer term staff had completed training in a range of subjects such as infection control, health and safety, first aid, fire safety, safeguarding, equality and diversity, the Mental Capacity Act 2005, dementia awareness and manual handling training. This was undertaken face to face and refreshed once a year during a two day session delivered by an external trainer. Staff had opportunities to study for nationally recognised vocational qualifications and the senior team also delivered bite size training on subjects such as nutrition, the use of PRN medicines and topical creams. Whilst staff were positive about the training provided, we were concerned that the system of delivering training just once a year meant new staff were often working at the service for several months before they received any training. We found this to be the case for the four staff whose records we viewed. Whilst the staff had received an induction during which they learnt about their role and responsibilities and spent time shadowing the more experienced staff, they had not received any training and had not, as yet, been enrolled on the Care Certificate. Some of the staff had not worked in a care setting before. The Care Certificate was introduced in April 2015 and sets out learning outcomes, competencies and standards of care that care workers are expected to demonstrate. Completing a suitable training programme, helps ensure that the registered manager and provider can be confident that new staff are supported, skilled and assessed as competent to carry out their roles. We have discussed this with the registered manager who has taken action to source a range of training delivered via DVD which will be implemented immediately and will moving forward, be rolled out to new staff as soon as they start working within the service.

However the failure to ensure that new staff received appropriate training and development is a breach regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Staff were receiving regular supervision and all of the staff we spoke with felt well supported in their roles and were confident they could approach the registered manager at any time with concerns or issues they might have.

Before a person came to stay at the service, an assessment of their care needs was carried out to gather information from the person and where appropriate from their relatives and any professionals involved in their care. The purpose of the assessment was to ensure that appropriate decisions were made about whether the service would be able to meet the person's needs. We noted that the assessment was basic and did not encourage the assessor to gather in any detail, information about the person and their needs. We also noted that the service had recently admitted one person whose needs, it had become apparent, they were unable to meet requiring them to give notice. To help avoid this in the future, we recommend that the service develop a more robust pre-admission assessment in order to support decisions about new admissions to the home.

Following a person's admission to the home, more comprehensive care plans were developed which described the person's needs in a range of areas such as personal care, eating and drinking, mobility and sleeping. Condition specific care plans were in place, for example, people had tracheostomy and catheter care plans. We did note that one person with insulin dependent diabetes would benefit from a more detailed escalation care plan which clearly described the actions staff should take if blood glucose results were outside of certain parameters. The registered manager has confirmed that action is now being taken to agree a more detailed care plan with relevant healthcare professionals.

We looked at how the design and layout of the building met people's needs. The accommodation was laid out over two floors with the first floor being accessed by a stair lift only. People could choose to spend their time in their room or in one of the communal areas which included a comfortable lounge, a conservatory and a small seating area, known as the 'railway carriage' near the front entrance. There was also a dining room, office space, a kitchen, laundry and a range of bathrooms with bath lifts and adapted toilets. Some areas of the home and some of the furnishings were a little worn and the décor was tired in places. We noted that people's rooms, whilst cosy and personalised to their individual tastes, were in some cases small, meaning there was limited space for guest chairs for example. Some of the rooms only had windows at standing height. The four first floor rooms were ensuite, but with baths which most people were unable to use. The ground floor rooms had wash basins only. We spoke with a surveyor employed by the provider and they explained that a refurbishment plan was underway. An improved call bell system had been installed and all of the windows had recently been replaced along with new window restrictors on the first floor. As furniture needed to be replaced, it was being exchanged for furniture with rounded, softer edges helping to prevent people knocking themselves on hard edges. An internal redecoration programme was planned for the spring and a kitchen refurbishment was also to be discussed by the Trustees.

People and their relatives told us that staff sought their consent before providing care and that they were encouraged and supported to make decisions about their care and support. Care plans contained signed consent forms to having photographs taken or for sharing information with others. Records were kept of which people had appointed a legal representative authorising a family member of friend to make decisions on their behalf when they were no longer able to.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The registered manager told us that people currently using the service were able to make their own decisions about their care and support and people's care records documented their individual choices about how they wished to be supported.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The home was not secure and people were able to freely leave via the front door as they wished. They were simply required to use a signing in/ out book for fire safety purposes. No-one living at the home was currently subject to a DoLS and no applications for a DoLS had been made. The registered manager told us that no-one currently met the criteria for a DoLS application but that this would be kept under review as people's needs changed.

Overall people were positive about the food provided. People's comments included, "It's very good," and, "The food is very good, I've had food I've never tried before like pasta but I like it". A relative said, "[the

person] always liked scrambled egg at home and they get it here". Hot and cold drinks were readily available throughout the day as was fresh fruit. The menus were planned with people and included a range of traditional meals such as roast dinners, pasta, and steak and kidney pudding. The evening meal was usually homemade soup and sandwiches. People could also have supper which might include foods such as fruit bread and cake. The registered manager oversaw the shopping and told us that people could request anything such as shandy, sparkling water and snacks such as crisps and this would be provided. Specialist diets were catered for such as gluten free and vegetarian.

At lunch, the majority of people came to the dining room to eat their meal, although, a small number had their meal taken to their room on trays. The meal appeared to be a pleasurable experience for people. The tables were laid with clothes, placemats and condiments were available. Two staff were available to support with serving the meals or to help people with cutting up their food if this was needed. Most people were however, able to eat and drink independently. People and staff readily chatted throughout lunch, following which people were offered tea and coffee. Adapted cutlery and crockery was available to support people's dietary needs, for example, a relative told us their family member had developed shaky hands so the staff had put her drinks in a special mug.

Where necessary a range of healthcare professionals including GP's, chiropodists, audiologists and community nurses had been involved in meeting people's health care needs. We were able to see that staff referred people for review by the GP if they were concerned about their dietary intake, or due to showing signs of having chest or urine infections. Clear records of all communications with health and social care professionals were kept and informed plans of care for people. For example, one person had been assessed by a speech and language therapist and their guidance and recommendations were clearly included in the person's care plan and staff had a good understanding of this need.

Good

# Is the service caring?

## Our findings

People told us they were cared for by kind and caring staff. One person said, "I like it so much here, nothing is too much trouble, they [the staff] are very kind and caring". A relative told us the staff were, "Ever so attentive, I have never heard anyone snap…they all have patience". Another relative said, "[family member] gets love and care". They told us their relative wouldn't come home for the day at Christmas as they were so happy at the home. They said, "I've always said there is no place like home, we have found there is". These thoughts were echoed by a health professional who told us, "It's very much a home from home".

Many of the compliments received by the service spoke of the kind and caring nature of staff. For example, one read, 'Thanks to the wonderful staff, this was perhaps one of the happiest years of [person's life]'. Relatives told us how staff cared for them as well with one telling us how throughout their family members end of life care, staff were, "Always there for me…I was never made to feel like they had something else to do". Due to an ongoing medical condition staff needed to attend to one person frequently to support them with this need. The staff were noted to be patient and reassuring each time.

People looked relaxed and happy in the company of the staff who throughout our visit appeared jovial, attentive and happy in their work. Staff interacted with people in a kind and caring manner and appeared to have developed positive relationships with people and valued them as a person. To demonstrate this, one relative told us that at Christmas, they had seen a staff member crying, when asked why, the staff member had said that one of the residents had just told them that it was the best Christmas they had ever had. They told us, "To my mind, that's the system working…all the staff are first rate". Staff spoke about their work and the people they supported in a positive manner, for example, one staff member said, "I like the fact that we can do something that has meaning, that can make a difference".

Staff recognised the importance of promoting people's independence and this was a particular strength of the service. For example, people were supported to maintain an active life in the community, such as visiting the local shops or attending local classes and clubs. Staff told us how they encouraged people to complete small tasks such as washing their own face. One care worker said, "Most people are very capable, but can want you to do it for them, I leave everything out and say, you make a start, nine times out of ten, they will do it fine.

The people living at Edwina Mountbatten House were mostly able to understand and make decisions about how their care and support was provided and we saw they were empowered and encouraged to do this on a daily basis. For example, during the inspection, a meeting was being held with one person, the registered manager and the chef to discuss the menu and how this might be improved. The person was able to suggest new recipes and methods for cooking. Their suggestions were taken on board. Staff respected people's choices, for example, one person had moved to a larger room but then realised that they preferred their original room and were supported to return to this.

Staff respected people's dignity and privacy. Staff told us how they knocked on people's doors before entering, or placed a towel across the person's lap when assisting them with personal care. Laminated signs

were readily available which people could place outside their door to help staff know they were resting and did not want to be disturbed. Staff could also use signs to identify to other staff or visitors that they were supporting a person with their personal care. Dignity champions had been appointed and were responsible for modelling best practice for the staff team. People, relatives and staff had contributed their comments to a 'Dignity Tree', celebrating examples of dignified care. One comment read, 'Thank you for your loveliness and respect and for making this a house of fellowship and family'.

The registered manager recognised the importance of people maintaining relationships with their relatives and friends, and encouraged these to continue after the person came to live at the home. People told us their relatives and friends were welcome to visit or where this was difficult, people were supported to use the internet to speak with their family members living some distance away. People were supported to follow their religious and spiritual beliefs. For example, Romsey Abbey services were now being streamed live into the home on a weekly basis.

Good

# Is the service responsive?

## Our findings

People told us they received care that was responsive to their needs. One person said, "They [staff] go out of their way to help…I would recommend here…They listen to what you say".

People received support which reflected their personal preferences, known likes and dislikes and choices about how their care should be delivered. These were described in a 'My Typical Day' document. For example, we saw that one person preferred to spend their time in the privacy of their room and enjoyed a cup of coffee on waking in the morning and that another person enjoyed wearing lots of layers. Care plans contained some information about the person's life before coming to live at the home. For example, we saw that staff knew that one person had used to be a vicar and so spoke with him about what this had meant for him. This supported staff to know and understand what was important to each person and helped then to deliver care that was responsive to people's individual needs.

People's involvement was evident throughout their care plans and quarterly reviews were held during which people were asked to comment on the quality of their care. Relatives felt that staff kept them well informed about all aspects of their family members care and that there were plenty of opportunities to have regular dialogue with staff and the management team.

A communication book was used daily by staff to share key information about people and a handover was held daily which helped to ensure staff were kept up to date with people's changing health and welfare needs. When concerns were noted about a person's health there was evidence that staff had responded by undertaking health checks, for example, checking to see if the person had a urine infection. We also saw that relevant referrals were usually made to healthcare professionals.

The Accessible Information Standard (AIS) is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The registered manager showed an understanding of the AIS and of the need to support people's right to have information provided to them in a format that met their communication needs. They told us that people's sensory needs and any barriers to their communication were assessed and monitored as necessary. They advised that should a person require information to be presented in a more accessible format, such as, large print or braille, this would be provided. We saw that to support one person's communication needs, staff were using a white board as a communication tool which we were told was working effectively.

The service did not employ staff to specifically lead the activities provision within the service. Instead most of the activities were led by the care staff. The activities were scheduled to take place at 11am each day and the entertainment for February 2018 included singalongs, exercises, a pub quiz, a coffee morning, quoits and bingo. During the inspection, we observed people being involved in crafts and completing crosswords with staff. A staff member also led a game of hangman which the two people who joined in seemed to enjoy. People were also supported and encouraged to continue to access the local community for example, two people had recently visited the cinema with staff and other events were also held such as such as boat trips

and afternoon teas using local community transport. One person told us, "Someone took us to the pictures, it makes you feel normal". The registered manager told us staffing would be adjusted to support people to attend activities and following a discussion about the menu during the inspection, they advised that an additional member of staff would be rostered at times to support people to get more involved in the cooking.

Most of the people we spoke with, told us they were satisfied with the range and number of activities provided and apart from the scheduled activities at 11am, most people spent the remainder of the day in their rooms. Most told us they were happy doing so and spent time reading, knitting or watching their TV. One person, however, told us, they would value more opportunities for companionship, they told us, "It would be nice to have a get together in the afternoon or after the evening meal". They were aware however, that many of the people currently using the service were not interested in this. Staff told us they did try and tempt people to spend more time in the communal areas but that this was often declined. They told us that if people did not want to join in the planned activities, then one to one support was offered instead.

People told us they were able to express their views and to give feedback about the service. Residents meetings took place. We reviewed the minutes of the last two 'Residents Meetings'. Topics discussed included the menus and the trips people would like to have organised. People told us they were confident they could approach the leadership team at any time with any concerns and that these would be listened to and dealt with and there was a suggestions box in the entrance. There had been no formal complaints since our last inspection, but a large number of people had positively commented on the care provided. Comments included, "A fantastic home, great staff, well organised and very homely". We did note that it had been some time since the provider had undertaken formal surveys with people to gather their views about the quality of the care provided. This is important as it helps to demonstrate how the provider has taken action to address any issues raised and used the information to drive improvements.

No one living at the service was receiving end of life or palliative care at the time of our inspection, however, there was evidence from feedback from relatives that people had been supported to receive good end of life and to have a comfortable, dignified and pain-free death. Staff told us how they had worked with a range of relevant healthcare professionals and provided support to people's families following their death.

We did note that the end of life care plans in place could be more comprehensive and include a focus on how the person might wish their care to be provided in their final days, rather, than events following their death. Senior staff told us it was sometimes difficult to have these conversations with people. We recommend that the registered manager review a range of resources to help support their staff to help people and their relatives feel empowered and positive about talking about death and dying and recording their wishes in relation this.

Requires Improvement

# Is the service well-led?

## Our findings

The registered manager had worked at the service for a number of years and had a good knowledge of the people living there, their needs and of the staff team. People, their relatives and staff spoke positively about their leadership of the home and of the person centred culture they had fostered. To demonstrate this a relative told us how the registered manager had sat up with a person who was dying, comforting her until they passed away. They told us that the registered manager had said, 'Nobody should die alone'. They explained that this gave them peace of mind that their relative would be cared for with love and dignity. It was clear from our observations that the registered manager had an excellent rapport with residents and staff. During our inspection, a relative came to visit and share their thanks for the care given to their mother before she died. They and staff exchanged hugs and spoke fondly of the person.

Staff spoke positively of the registered manager with one saying, "This is the only place I have never dreaded to coming to work at, [the registered manager] is very approachable, the residents love her, she knows them well". Staff told us that the service was a good place to work and that they enjoyed their job. Staff meetings took place periodically. These meetings were used to share developments with staff and to discuss how the delivery of care could be enhanced.

We found, however, that some improvements were needed to how the service was managed. During the last year the manager had on occasion, admitted more people to the home, than their registration conditions set by the Care Quality Commission allowed. This indicated a lack of understanding of their legal responsibilities as registered manager. As reported elsewhere in this report, the registered manager had not ensured that new staff had access to the training and development they required. Some of the records relating to people's care needed to be more comprehensive and identify how risks were being acted upon. For example, two people had been assessed as being at high risk of poor skin integrity but did not have a skin care plans. One person had been assessed as being nutritionally at risk. Their care plan said they should be weighed weekly and had been placed on food and fluid charts to help monitor this. We reviewed the food and fluid charts and found that whilst these had been fully completed, staff were not totalling the amount of fluids the person drank each day in order that action could be taken if this was too low. The weight records were not recorded in a manner which helped to clearly identify if the person was losing weight, for example, they were sometimes recorded in metric and sometime in imperial measures. Staff were not calculating any weight lost or gained. We noted that another person was choosing to eat at risk and understood the risks associated with this, but their eating and drinking care plans did not accurately reflect how staff were monitoring this risk.

Whilst there was evidence that the registered manager valued people's feedback about the service and had made changes in response to this, we found that overall, more sophisticated systems were needed to measure the quality of the service against the fundamental standards, key lines of enquiry and best practice guidance. Whilst medicines and care plan audits were being undertaken on a regular basis, these had not identified the concerns we found during the inspection.

The board of Trustees met on a monthly basis to review issues related to the running of the home and

undertook visits to the service to assess the quality of care, however, we found that these visits would benefit from more clearly assessing the quality of the service against the fundamental standards allowing them to assess emerging risks and compliance with the Regulations. A Trustee told us that they had already identified this and were considering ways in which they could add more value to their monitoring visits.

There was a failure to ensure that systems and processes were in place and were operated effectively to ensure compliance with the Regulations and to assess, monitor and improve the quality of the service. This was a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

The provider and registered manager had a good understanding of the challenges facing the service. They were aware that people were coming to live at the service with increasingly complex and long-term conditions which had implications for a range of areas such as staffing numbers, their skills and knowledge and the physical environment of the service. The provider and registered manager were updating their business plan to ensure it was resilient to these challenges in the future, for example, plans were being developed to update and 'future proof' the building to provide better living areas and better staff facilities. Research was also underway to explore options for an electronic care planning system that would suit the needs of the service.

The registered manager had a clear value base, central to which was the belief that each person should be able to live in a safe and comfortable environment, where they were treated with respect and equality. A particular strength of the service was the way in staff recognised the importance of people's autonomy with the amount of care being provided being 'just enough' to meet their needs without taking away their independence. It was clear that people's freedom and choices were respected and care was not provided in an overly risk adverse way. This supported people to continue to live as normal a life as possible but in the knowledge that the care and support of staff was available should they need it. The registered manager told us, "I truly believe people are here to live…if we can find something to make someone smile, we will do it".

People were supported to maintain links with the local community within which they lived. For example, local youth groups visited to put on cream teas and local choirs and brownie groups visited to entertain people. People attended events at a nearby community hall and talks were organised from local historians. People used the local shops either independently or with staff support.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There was a failure to ensure that systems and processes were in place and were operated effectively to ensure compliance with the Regulations and to assess, monitor and improve the quality of the service. Records relating to people's care were not always complete. This was a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Good Governance. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered manager had failed to ensure that new staff received appropriate training and development. This is a breach regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Staffing. |